

GREEN (With the kind regards of  
The Author)

A VIEW  
OF  
MODERN SURGERY

FROM THE STANDPOINT  
OF A GENERAL PRACTITIONER,

BY

JAMES S. GREEN, M. D.,  
OF ELIZABETH, N. J.

---

President's Address, delivered before the  
New Jersey Medical Society, June, 1891.



L. J. Hardham, Printer, 243 & 245 Market Street, Newark, N. J.

1891.



A VIEW  
OF  
MODERN SURGERY

FROM THE STANDPOINT  
OF A GENERAL PRACTITIONER,

BY

JAMES S. GREEN, M. D.,  
OF ELIZABETH, N. J.

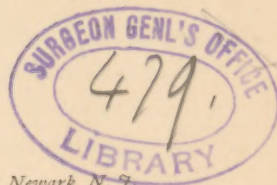
---

President's Address, delivered before the  
New Jersey Medical Society, June, 1891.

---

*L. J. Hardham, Printer, 243 & 245 Market Street, Newark, N. J.*

1891.







# MODERN SURGERY.

---

## A VIEW OF MODERN SURGERY FROM THE STANDPOINT OF A GENERAL PRACTITIONER.

The era of modern surgery commenced with the discovery and practical use of anæsthetics.

For many years surgeons had vainly endeavored to prevent the sufferings of those who were obliged to submit to the pain inflicted by the knife, the cautery, the pulley and the various means in use in the practice of surgery. Some of us well remember in our early professional life the scenes of intense pain, the terrible dread and anticipation of the patient before the operation, the means used to confine the patient during his sufferings and the difficulties encountered by the surgeon almost overcome by his sympathies and thwarted by the throes of the subject on the table before him.

Happily for humanity in October, 1846, Dr. Warren, of Boston, demonstrated the fact that sulphuric ether could be used satisfactorily in capital operations for the entire prevention of pain, and from this time (although at first this new boon was received with great caution and incredulity) the use of ether became more and more welcome, until now its use is general wherever surgery is practiced.

In November, 1847, Professor Simpson, of Edinburgh, after personal experiments with chloroform introduced

this anæsthetic to the profession, and for more than twenty years it was accepted in preference to ether except in this country, in Lyons, France, and in Naples, Italy. But the more frequent fatal results occurring after the use of chloroform made the profession cautious, and at this time it is generally administered to relieve pain during labor and in operations upon children or in cases where vomiting after the operation would endanger the success of the procedure. Local anæsthesia produced by benumbing the part to be operated upon by a mixture of ice and salt or by the spray of ether or rhigolene has been superceded by the use of the solution of the hydrochlorate of cocaine. In 1884, Dr. Koller, of Vienna, demonstrated its usefulness when applied to mucous membranes, especially to the conjunctiva. Since which time it has been applied to nearly every mucous membrane. Local anæsthesia of the skin and sub-adjacent tissues by the hypodermic injection of cocaine giving entire relief from pain in such operations as removal of the toe nail, in circumcision and in any situation where the method first described and advocated by Dr. J. Leonard Corning, of New York, is thoroughly carried out, gives the surgeon the use of an anæsthetic whose action is sufficiently prolonged to accomplish painlessly any operation (to which cocaine can be applied) without unpleasant reaction or constitutional effect. The method devised by Dr. Corning for this purpose, consists in injecting a solution of cocaine beneath the skin of the part to be anæsthetized, and after waiting a few moments to allow the cocaine to affect the nerves of the surrounding parts an elastic band producing compression is applied between the place of injection and the heart. Twenty or thirty minims of a 4 per cent. solution may be injected at different points, an inch apart, along the line

of the incision to be made. After the first injection the subsequent ones are painless. The tourniquet may be allowed to remain for a half an hour or more if desired, during which time no diminution of anæsthesia will be noticed. The late Dr. Theodore R. Varick reported to me a case of amputation of the lower limb in a man unable to take ether or chloroform, in which the member was removed without pain after the injection of cocaine by Dr. Corning. Our time and space will not permit us to pursue this interesting subject any further, but the use of cocaine should always be borne in mind as being preferable to general anæsthesia when it can be employed. The possibilities of cocaine as an anæsthetic have not yet been fully appreciated by the profession at large.

The proper care and dressing of wounds, whether made by the surgeon's knife or caused by accident, have always been one of the greatest and most anxious solicitudes of the profession. Recognizing the fact that the well-being of the patient and the success of the operation depended upon the manner in which the part injured was taken care of the ingenuity of the surgeon has devised many modes and employed many substances to accomplish the purpose never reached until within a few years. The purpose of the earlier surgeons seemed to be the production of pus, which, when of a suitable color, odor and consistence was crowned with the name of "laudable," a pus to be praised. So afraid were the early French surgeons of primary union after amputations, that they inserted between the edges of the stump a piece of lint to prevent what was known as a "stump abscess." This was their mode of drainage. Water dressings, warm, hot and cold, applied to the parts by various substances, such as charpie, lint, tow, etc., have been used almost continuously since the days of Ambroise Pare. Wounds thus



dressed were not exposed to the open air and were thus in a measure protected from germs floating in the atmosphere of hospitals. The result obtained was rarely primary union except in small incised wounds when the parts had been thoroughly cleansed and brought into perfect coaptation. Suppuration was always expected in the healing of large wounds when this method was used. In 1856 the "open method" of dressing amputations was advocated by a few German surgeons and was shortly after practiced by Dr. James R. Wood in this country. The wound was freely exposed to the air. A small vessel or a pad of some absorbent material being placed under the stump to receive the discharges. When granulation was thoroughly established the surfaces of the wounds were approximated by adhesive plaster. In this method the drainage was perfect, although an open door was left for infection from without.

One serious objection arose to the use of the "open method" namely, that it required from six to twelve weeks to effect a cure.

Dr. Frederic S. Dennis published in the *New York Medical Journal*, January 1876, an account of the "open method," and of fourteen consecutive major amputations all successfully treated in the service of Doctor James R. Wood, in Bellevue Hospital, by the "open method." Up to that date the percentage of deaths was one in three in such cases, in large hospitals.

Dr. Dennis claims that :—"The cardinal principle involved in this method of dressing is, that of preventing suppurative fever, and this object is obtained by leaving the stump entirely open, thus allowing of free and continuous drainage."

Professor William Gibson of the University of Pennsylvania in lecturing upon punctured wounds, announced



as an incontrovertible fact, that tetanus never occurred in cases of punctured wounds, where pus was formed in the wound, and recommended hot poultices to induce suppuration.

In 1872, Dr. Addinell Hewson advocated the use of prepared earth or dried clay, in direct contact with wounds as a dressing, and claimed remarkable results.

Sir J. Y. Simpson, in 1864, declared "that after the sides and edges of a wound are properly approximated and adjusted with metallic stitches, the best dressing as a general rule is—nothing—absolutely nothing."

In 1865 the method of pneumatic occlusion practiced by Guérin, and of pneumatic aspiration proposed by Maisonneuve, by which all air was either occluded or withdrawn from the wound were advocated.

We have already consumed much time in detailing some of the prominent methods which have been used in the dressing of wounds, some of which are absolutely opposite to the others, and yet all praised by their advocates as the best, and giving the most successful results.

What is the legitimate inference to be drawn from the use of these various and dissimilar methods? That they were empirical, the result of the ignorance of the profession of the fundamental principles, which now govern the surgeon in these more enlightened days—doctrines which the labors and studies in the laboratory have furnished us. The knowledge of our surgical enemies, their ways, the means for their destruction, the methods for preventing their reproduction, and their exclusion from wounds.

Before the true basis of anti-parasitic surgery had been ascertained, some surgeons were impressed with the belief that the suppuration following surgical or accidental wounds was produced by the presence of living micro-organisms. The germ theory of disease was prophetically

foreshadowed in 1849, by Prof. J. K. Mitchell of Philadelphia, in his paper entitled "On the Cryptogamous Origin of Malarious and Epidemic Fevers."

Sir Joseph Lister in his remarks before the Surgical Section of the International Medical Congress in Philadelphia in 1876, says "The germ theory of putrefaction is the foundation of the whole system of antiseptic surgery, and if this theory is a fact, it is a fact of facts, that the antiseptic system means the exclusion of all putrefactive organisms." Former surgeons sought to produce suppuration and prevent primary union, modern surgeons aim to prevent suppuration and expect union by first intention.

The constant researches and thorough experiments which have been made in the laboratory have convinced the profession of the truth of Professor Lister's axiom, delivered fifteen years ago. The germ theory being accepted as proven by the profession at large.

The Listerian principle carried out in the treatment and care of wounds has so uniformly produced successful and satisfactory results that the statement of Dr. Gerster in his admirable work on "Aseptic and Antiseptic Surgery," must be accepted without cavil. He says "It cannot now be successfully denied that the surgeon's acts determine the fate of a fresh wound, and that its infection and suppuration are due to his technical faults of omission or commission. The principle underlying antiseptic surgery has ceased to be the subject of serious controversy."

The recent attack of Lawson Tait upon Sir Joseph Lister has not shaken the belief of the profession at large in antiseptic surgery, the onslaught being evidently the effort of a malignant man actuated by personal spleen. His unfair and irrational criticism has been entirely destroyed by Dr. J. William White, of Philadelphia.

It is not my purpose to enter into a description of the technique of antiparasitic surgery, or to detail the changes that have occurred in the last fifteen years in its practical working. Two books, one upon the "Principles of Surgery" by Professor N. Senn, and one upon "Aseptic and Antiseptic Surgery," by Professor Arpad Gerster, will furnish the earnest inquirer and busy general practitioner with all the information desired, and the knowledge possessed up to the present time.

The modern surgeon has another important advantage in the means possessed for the prevention and arrest of hemorrhage. He proceeds in his work without fear of blood loss, having either removed the blood from the parts to be operated upon by position or by elastic pressure, through the use of Esmarch's or Martin's bandage, and by dextrous employment of the various forms of hemostatic forceps at the moment the vessels are divided. The thermo-cautery of Paquelin also renders him prompt assistance when the source of the flow of blood cannot be reached by ligature.

The hypodermic syringe promptly introduces into the circulation, stimulants, at the time when the heart has well nigh ceased to act.

The modern surgeon who has kept abreast with the recent discoveries relating to etiology, pathology, and treatment of surgical diseases and who has carefully studied the diagnosis and prognosis of such diseases, who has acquired a thorough knowledge of anatomy, not only the anatomy of the cadaver, but "an appreciation of tissues" by which he recognizes living tissues, and distinguishes between them under all circumstances, armed with the means we have described, is constantly adding to the wonderful achievements which have marked particularly the history of the last ten years of the era of modern surgery.



It would be impossible to relate in the time allotted to an address, all the useful operations modern surgery has established, much less to detail what it has attempted, but there are some developments which require our notice, from the fact that they have materially added to the sum of human life and happiness.

Modern surgeons have paid especial attention to the region of the abdomen containing, as it does, so many organs, readily approachable through its walls, and without much risk of fatal results, when antiseptic precautions are thoroughly and carefully practiced.

*Appendicitis.*—This disease has been very carefully studied during the last four years. Since the reading of the able paper upon this subject by Dr. Reginald Fitz, of Boston, before the Association of American Physicians in 1886. No disease within the range of surgery has received more careful attention; and many contributions upon this interesting subject have been made by the ablest surgeons, and especially by those of this country. This valuable knowledge has been gathered within a short period, by those who have had the opportunity afforded them by early laparotomies in this disease, of studying its varied conditions, giving a more thorough and accurate knowledge of the pathological process involved from its inception.

Dr. Charles McBurney states "We have learned that there is no such disease as idiopathic peritonitis, and that excluding the special causes of peritonitis, which exists in the female, the cause of the vast majority of cases of peritonitis, is an inflammatory process originating in the appendix. We have learned that the appendicitis is a disease of frequent occurrence, that it is responsible annually for a large number of deaths, and that none of the older methods of treatment afford the practitioner any actual

control of the disease, although medical treatment, rest, and intelligent nursing are doubtless of great value in limiting the extent and shortening the duration of milder attacks." Every physician remembers that during his practice there have been cases of peritonitis which have ended fatally (in which no post-mortem examination could be obtained) whose untimely end has made him realize how inefficient he was to relieve suffering and save life.

The statistics of appendicitis, treated medically and conservatively, show from twenty-five to thirty per cent. of deaths, while the surgical experience of McBurney, Weir, Bull, L. A. Stimson, Senn, Treves, Keen and many others, who have operated give most favorable results.

It is almost generally admitted that early laparotomy in recurrent appendicitis is not only justifiable, but absolutely demanded.

It becomes every surgeon to carefully study and weigh, the value of each symptom of this disease. Abdominal pain always is present, varying in degree and even referred occasionally to the left side of the abdomen, the epigastrium or umbilicus. Sometimes there is a chill in the early onset accompanied with vomiting; while in others cases both or either symptom is absent. Fever following varies in intensity, the temperature ranging from  $100^{\circ}$  to  $103.5^{\circ}$ . Tympanitis is also variable in degree; there is general rigidity of the muscles of the right side of the abdomen. "McBurney's Point" affords the most important test. He describes it thus, "but if firm pressure is made with the finger tip, and especially if the patient be made to cough, while such pressure is being exerted, it is invariably easy to determine that the most sensitive point is a definite one in most cases. This point is very accurately located in the adult, from  $1\frac{1}{2}$  inches to 2 inches inside of

the right anterior-superior spinous process of the ilium, on a line drawn toward the umbilicus. In children it is in proportion to their size, so much less distant from the spinous process. No other acute disease presents this feature. The accuracy of this sign I have demonstrated in every case operated upon by me since I first made the observation. The point described corresponds very accurately in the living subject, to the base of the appendix." A tumor can in most cases be detected in the right iliac fossa by the end of the second or third day.

The use of the hypodermic needle, as proposed by Dr. W. T. Bull, in his paper read before the "Medical Society of London," 1888, as a means for the discovery of pus, has now been laid aside, for the same reasons that it is no longer employed in ovarian and other tumors within the cavity of the abdomen.

The question of the time for the performance of laparotomy is a vital one for the patient. According to Fitz's tables, of 176 cases of perforative inflammation of the appendix, 60 died during the first five days; 46 during the first four days, and 28 during the first three, while eight only died on the second day. The cases to which we are called with well-marked symptoms of appendicitis should be carefully watched, and if the symptoms do not increase, but are in a slight measure diminished, after the first twelve hours, there is every reason to hope that the case will speedily recover from this attack. McBurney lays down the rule: "In cases, which at the end of thirty-six hours from the beginning, show well-marked signs of increasing disease, the question of an operation should be deliberately and carefully discussed, and in my opinion done."

It is a safe rule to be prompt in the performance of any operation before the parts to be reached become necrotic.



How many cases of strangulated hernia have been lost by too long continued taxis and conservative treatment, so called.

Dr. Robert F. Weir in the *Annals of Surgery*, for May, 1891, "On the resection of the appendix vermiformis during the quiescent stage of chronic relapsing appendicitis," writes that "until recently I was opposed to operate between the attacks of chronic relapsing appendicitis, and thought it was wiser to delay the operation until an acute attack was in progress. Since that time experience has grown with great rapidity in this department of surgery. I have been able to collect some 26 cases, probably not all that have been published, but they contain a sufficiently large number to enable me to draw deductions, somewhat different from these that came into my mind a year ago.

Considering now, in detail, the twenty-six collected cases, I have found but one death. The mortality of the operation therefore must be considered to be a slight one, and in all the cases that have recovered, the recovery has been satisfactory."

Dr. Joseph Price of Philadelphia, writing on the same subject, says: "The surgery that waits for a general peritonitis, before it interferes with a condition that may cause it, or hesitates to operate upon a patient with general peritonitis because *it is possible for recovery without operation*, lends itself to an operation both against the science of surgery and the sanctity of human life."

Dr. W. W. Keen has contributed an admirable article entitled, "The Indications for Early Laparotomy in Appendicitis," in the *Annals of Surgery*, April 1891. In the same number there will be found two valuable papers on "The Operative Technique of Appendicitis," one by Dr. Lewis H. Stimson, of New York, and the other by

Dr. George R. Fowler, of Brooklyn. Dr. McBurney's first paper, entitled "Disease of the Appendix Vermiformis" was published in the *New York Medical Journal*, Dec. 21, 1889. Dr. L. A. Stimson has a contribution on the same subject, *New York Medical Journal*, Oct. 25th, 1890.

It is a fact that the surgical treatment of appendicitis, which has afforded such remarkably satisfactory results, has been developed in the last four years, and that almost entirely by American Surgeons.

To Sir Joseph Lister is due the credit of reviving the operation of supra-pubic cystotomy. Although performed by Pierre France in 1554, and revived from time to time for cases of stone, which could not be removed by lithotomy or lithotrity, it was seldom used on account of the mortality which accompanied it. It is now recognised as one of the standard surgical proceedings.

"It is used successfully for removal of tumors within the bladder, as a means of drainage in cystitis, as a mode of exit for the urine when it cannot be passed by the urethra, for the purpose of removing hypertrophied lobes of the prostate, obstructing the flow of urine, as a means of cure in otherwise incurable perineal fistula."

The treatment of Phlegmon by aseptic and antiseptic surgery, whether that of the bony or soft tissues, is one of the most important advances made by modern surgery, being required in every day practice, and affording vastly different results than those reached formerly.

I cannot do better than quote from page 222 of Gerster's "Aseptic and Antiseptic Surgery," his conclusions upon this subject.

"*Prevention of Infection* contains the spirit and aim of aseptic surgery; the object of *Antiseptic Surgery* is *Disinfection*, and the *conservation of infected tissues*. The first object is attained by a severe discipline of *cleanliness*,

the second by a still more severe discipline of *early incisions* and adequate *drainage*, and *disinfection*.

"A clear comprehension of the processes determining suppuration must result in the firm conviction that an early and free incision of every focus of septic inflammation, is the most conservative form of treatment. It prevents local death and general intoxication, the latter only too often the cause of general death.

"If this conviction shall have entered into the '*Succum et Sanguinem*' of every physician, public opinion will gradually yield to a better understanding of the individual and the public interest.

"Note.—The change in the surgeon's attitude toward the employment of incisions for septic inflammatory processes is characterized by these sentences:

"*Formerly* topical applications were the main reliance; incision only at last and extreme resort. *The Surgeon had to show cause why an incision should be made.*

"*At Present*, relief from tension, and escape of the noxious substances through the incision, and drainage is the clear indication to be fulfilled. *The Surgeon must show cause why an incision should not be made*, in the presence of a septic inflammation."

Want of time will allow us merely to mention the treatment of tubercular glands and joints, by the complete removal by excision or Volkmann's spoon, under aseptic precautions of every focus of tubercular infection and the subsequent dressing under antiseptic rules, combined with proper hygienic and general constitutional treatment.

In the department of orthopædic surgery there is one operation that deserves especial notice, affording most satisfactory results in cases of talipes, equinovarus and pes valgus, namely Phelps's operation, consisting of the tenotomy of the tendo-achillis, the division of the plantar



fascia of all the soft parts, the tendons of the several muscles, the ligaments, nerves, and if necessary the vessels to the bone, continuing the incision, if required, into the joints between the tarsal bones. The incision commences from the tip of the internal malleolus, and extends downwards for one inch. The foot having been previously exsanguinated by an elastic bandage, the parts can be carefully reviewed, every vessel tied and constricting fibre divided.

The foot being brought into the natural position, after thorough irrigation, a piece of rubber tissue is placed over the gap made, the wound dressed aseptically, and while the foot is held in the proper position by an assistant, a Plaster-of-Paris bandage is applied and allowed to remain for two or three weeks; on removal it will be found that a cure has been effected in nearly every instance, and that the gap in the inside of the foot, made by the incision and eversion of the toes has been filled with sound tissue made by the "organization of the moist blood clot," according to Shede's method.

The treatment of burns antiseptically does not appear to have had the consideration in the standard surgical works that its importance demands. The trite recommendation of the application of carron oil, applied with cotton batting to the parts without any directions or means for cleansing them, also Goulard lotion on lint, are at variance with the present accepted rules for the cure of wounds.

In a little book by Dr. Robt. T. Morris of New York, entitled, "How we Treat Wounds To-day," a nearly complete description of the treatment of this oft-occurring accident will be found. In the hospital with which I am connected the staff go even further than Morris directs.

After the patient is anæsthetized, and the clothing removed, the parts being thoroughly washed with a proper

carbolic acid solution, or a solution of the bichloride of mercury, 1-5000; the parts adjoining the burn are shaved and thoroughly cleansed, then the surface of the burn and its edges are scraped with a Volkmann's spoon. Having removed all the dead and floating matter by irrigation, the parts are dried with absorbent cotton and sprinkled with a slight coating of iodoform; protective tissue is then placed over the whole wound, and a full antiseptic dressing. This is allowed to remain (unless a rise of temperature occurs) for a number of days; or the odor from the parts demand an earlier dressing. Of course in cases accompanied with great shock, or extensive destruction of surface, this thorough primary removal of the surface would not be attempted.

The results have been most satisfactory. Most of the cases have been cured without the formation of pus.

Modern surgery has wrought her greatest wonders in the region of the brain. The cavity of the skull was formerly supposed to contain but one organ, acting in its entirety, as the heart, the liver, or the spleen, but modern researches, since 1861, have established the existence of special areas of the cortex with special functions: motor areas with their affections; the visual area and its affections, and the cortical areas, governing language.

With the knowledge of these various areas and their affections, the surgeon, assisted and guided by the physiologist and psychologist, has been able to locate and relieve by operation, disease within the cranium, including lesions beneath the cortex, in the tracts of conduction, whether of special sense or motion, with a certainty growing more and more positive every day.

I quote from Dr. M. Allen Starr's work, entitled, "Familiar Forms of Nervous Disease," he writes:—

"The theory of localization of brain functions is now

established, it is now no longer a matter of doubt that each part of the organ has its own work to do; and already the practical application has followed and cerebral surgery has its accepted place in therapeutics.

"The brain is no longer an organ exempt from surgical interference. It becomes therefore a necessity for every physician to be in possession of those facts which are essential to the diagnosis of local cerebral disease, to be able to decide upon the possibility of surgical interference, to be able to direct the surgeon where to trephine."

Operations in case of Jacksonian epilepsy have been frequently performed, but with varying success, but the safety of the operation being assured under antiseptic precautions, it has become proper in severe cases in which the seizures are frequent. These cases have been successfully operated upon by Weir, Keen, Park, Macewen, Horsely and Bergmann.

Tumors of the brain have been successfully removed by Weir, Keen and others.

In the table (to be found in the *Reference Hand Book of Medical Sciences*, in the article, "Brain," by Dr. W. W. Keen,) of seventeen cases of intracranial tumors reported, upon which operations were done, eleven recovered and six died. This table is dated 1888, and the mortality at that time was but 33.3 per cent, but with the improved technique which experience gives, and the ability to select cases for operation, the mortality will be reduced to a minimum.

What the possibilities of this branch of surgery are, cannot be determined at this time, with our present limited knowledge, but there is unquestionably a brilliant future before it.

Anæsthetics having rendered surgery endurable, and antiparasitic precautions having made surgery a most prob-



able success, large fields of study and investigation were opened in every branch which the busy practitioner had not time to cultivate. Hence there sprang up an army of investigators to develop these new fields, who have been called specialists. They have done a wonderful work by devoting themselves entirely to one subject; acquiring great skill in diagnosis, and facility in operation.

Most of the earlier ones came from the ranks of general practice with a thorough knowledge of medicine in all its branches, and thus thoroughly furnished, were symmetrical in their work and their thought.

Man, being a fallible creature, is apt to become one-sided when his mind is constantly directed to one object, as the plant grows which continuously has one portion of it exposed towards the light. On this account the specialist who has not had the widening effect of general practice, is liable to see the cause for symptoms and disease, through the medium only of his own specialty, and may sometimes ride his hobby so constantly that the general practitioner looks upon him with caution.

A female patient is the victim of an almost incessant headache; she visits one specialist, who gives as the cause an uterine displacement, and recommends a pessary, or possibly Alexander's operation. Another may find a pyosalpinx, and advises the removal of the uterine appendages, a third finds her trouble due to eye strain, want of accommodation, and recommends tenotomy of one of the recti muscles, or the adjustment of glasses, while the whole trouble may be relieved by simple laxative treatment.

While it is true, that the earnest pursuit of one grand object is the prime factor of success, the young physician makes a great mistake if he adopts a speciality before a few years of general practice shall have given him the

opportunity to learn to which special branch he is adapted. A few words on the moral obligations of the modern surgeon, and I am done.

Dr. John H. Brinton, in the *International Encyclopedia of Surgery*, edited by Ashurst, in speaking of the qualifications of the surgeon, writes:—

“In the first place he must be thoroughly *honest*, he should operate only in the interests of his patient's highest good, where life is to be saved. or discomfort or deformity relieved; he ought never to be tempted even by importunity to perform an unnecessary operation, nor to operate for the sake of display, nor in the desire of acquiring notoriety or fame, nor for the sake of linking his name with this or that procedure.

“In doubt, he should try always to place himself as it were in the patient's place, and before deciding upon an operation, at all times be able to answer distinctly and affirmatively, the self-directed question:—Is the proposed surgical interference really for my patient's good?”

I fear (while I do not wish to bring any of my profession to the bar of public opinion) that some facts which have come to my knowledge warrant the opinion that all surgeons are not governed by the principles laid down in the sentences just quoted. An example will suffice. The wife of a man in very moderate circumstances had a tumor developed in her arm at the insertion of the deltoid. It was not painful, but inconvenient from its increasing size. It was removed by a surgeon of the city in which she lived.

After its extirpation, examination revealed that it was a sarcoma. In two months it returned near the shoulder joint, the patient went to the neighboring metropolis, entered an hospital, and suffered an amputation of the shoulder joint.

The disease returned in the cicatrix, and the patient was advised to submit to the removal of the scapula clavicle and the mammary gland, notwithstanding the fact that a deposit was developing in the cavity of the chest of the opposite side. All these operations were successful, as far as recovery from the operation was concerned, but the patient died in less than six weeks, of sarcoma of the lung of the opposite side. The poor man lost his wife and the little property he had, in paying his doctor's bill.

There is another fault into which some of the profession have fallen, namely, the misguiding character of the statistics of operations performed by them.

Their mode of making tables of cases, gives rise to the suspicion that they were made in the interest of the operator's reputation, or for self-glorification, rather than for the information of the profession, of the value of the operation in relieving the trouble for which the patient submitted to the knife.

Perfect diagnosis, technique and experience should make failure almost impossible, if cases for operation are properly chosen. Hence, statistics which tell of one hundred cases, all of which recovered from the operation, except two which died, and say nothing of the relief the patient was afforded, are of no value in determining the usefulness of the operation for the relief of human suffering, but simply inform the world, that the gentleman who did the work, is a great surgeon in that special branch. The result is, that after many have passed through much trial in the interests of science, so called, but more in the interests of the reputation of certain surgeons, the proceeding having been condemned by general public opinion, is dropped from the lists of useful operations.

I believe I cannot close this address in a better way

than by quoting a paragraph from a lecture by that great surgeon Sir James Paget "On the Calamities of Surgery," he writes:—

"Next let the liability to these calamities move you never to decide upon an operation, except in consideration of the patient's interests alone. Let no thought of your own interest or of your own reputation have any place in the consideration of what is to be done for this or that man.

If an operation is not purely and wholly for the good of a patient, it should on no consideration whatever be done. When an operation is decided on, you may add a desire for your own reputation to the motives, that will induce you to do the best you possibly can for the patient, but this, which is a very fair motive for the careful performance of an operation, is a very foul one in determining whether an operation should be done or not.

I can imagine nothing that would add more to the remorse of a man who had fallen into one of these calamities of surgery, than the recollection, that he proceeded to the operation with some consideration of his own interests or his own reputation."











